entities that are not Federally qualified HMOs, for the services specified in § 434.21(b), the plan must include a State definition of an HMO. Under the definition, the HMO must meet at least the following requirements:

(1) Be organized primarily for the purpose of providing health care services.

(2) Make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to nonenrolled Medicaid recipients within the area served by the HMO.

(3) Make provision, satisfactory to the Medicaid agency, against the risk of insolvency, and assure that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

(d) *Services that may be covered.* A contract with an HMO or a PHP may cover services to enrolled recipients that are not provided under the plan to nonenrolled recipients as permitted under § 440.250(g) of this chapter.

(e) *Requirements for all contracts.* For all contracts with HMOs or PHPs—

(1) The contract must meet the requirements of § 434.6;

(2) The Medicaid agency must carry out the responsibilities specified in subpart E of this part; and

(3) The contract must provide that any cost-sharing requirements imposed for services furnished to recipients are in accordance with §§ 447.50 through 447.58 of this chapter.

[48 FR 54020, Nov. 30, 1983, as amended at 55 FR 23744, June 12, 1990; 55 FR 51295, Dec. 13, 1990; 56 FR 10515, Mar. 13, 1991]

ADDITIONAL REQUIREMENTS

§ 434.21 Contracts that must meet additional requirements.

(a) Unless otherwise indicated, the additional requirements set forth in §§ 434.23 through 434.38 must be met in all types of contracts with HMOs and PHPs:

(1) Nonrisk contracts;

(2) Risk comprehensive contracts; and

(3) Other risk contracts.

(b) Risk comprehensive contracts are risk contracts for furnishing or arranging for comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services or groups of services:

(1) Outpatient hospital services and rural health clinic services.

(2) Other laboratory and X-ray services.

(3) Skilled nursing facility (SNF) services, early and periodic screening, diagnosis and treatment (EPSDT), and family planning.

(4) Physicians' services.

(5) Home health services.

(c) Other risk contracts are risk contracts for a scope of services other than those specified in paragraph (b) of this section.

[48 FR 54020, Nov. 30, 1983, as amended at 55 FR 51295, Dec. 13, 1990]

§ 434.22 Application of sanctions to risk comprehensive contracts.

A risk comprehensive contract must provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by HCFA under § 434.67(e).

[59 FR 36084, July 15, 1994]

§ 434.23 Capitation fees.

The contract must specify—

(a) The actuarial basis for computation of the capitation fees; and

(b) That the capitation fees and any other payments provided for in the contract do not exceed the payment limits set forth in §§ 447.361 and 447.362 of this chapter.

§ 434.25 Coverage and enrollment.

(a) The contract must provide that—

(1) There will be an open enrollment period doing which the HMO or PHP will accept individuals who are eligible to be covered under the contract—

(i) In the order in which they apply;

(ii) Without restriction, unless authorized by the Regional Administrator; and

(iii) Up to the limits set under the contract; and

(2) Enrollment is voluntary.

(b) Risk comprehensive contracts with HMOs must also provide that the HMO will not discriminate, against individuals eligible to be covered under